

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/29/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT HOSPITAL & HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one State complaint.</p> <p>Complaint Number: IN00095290 Unsubstantiated: Lack of sufficient evidence</p> <p>Facility #: 005075</p> <p>Survey Dates: 03-28/29-12</p> <p>Surveyor:</p> <p>Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor</p> <p>St.Vincent Hospital & Health Services was found in compliance with 410 IAC 15-1.5-6, Nursing services, 410 IAC 15-1.6.7, Respiratory care services, 410 IAC 15-1.6.2, Emergency services and 410 IAC 15-1.5-8, Physical plant, maintenance, and environmental services, Hospital Licensure Rules.</p> <p>QA: cloughlin 04/30/12</p>	S 000			

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1